HOUSING & HEALTH

PUBLIC HEALTH IMPLICATIONS OF THE CRISIS IN AFFORDABLE HOUSING

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CITY OF TORONTO
DEPARTMENT OF PUBLIC HEALTH

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SOCIAL ENVIRONMENT WORK GROUP

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A.S. Macpherson, M.D., M.Sc.
Medical Officer of Health

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TABLE OF CONTENTS

		Page
	ACKNOWLEDGMENTS	iii
	EXECUTIVE SUMMARY	1
1.	INTRODUCTION	6
	1.1 Toronto's Affordable Housing Crisis	7
2.	HOUSING AS A HEALTH ISSUE	10
	2.1 Department of Public Health Experiences With Inadequate Housing	10
	2.2 Groups at Risk	11
	2.3 Dimensions of Housing Inadequacy	13
	2.3.1 Affordability	13
	2.3.2 Physical Quality	16
	2.3.2.1 Housing By-law	20
	2.3.3 Homelessness	23
3.	HOUSING INITIATIVES IN TORONTO	26
	3.1 Role of the Department of Public Health	27
	3.1.1 Unaffordability	27
	3.1.2 Physical Deterioration	28
	3.1.3 Homelessness	29
4.	SUMMARY AND CONCLUSIONS	30
5.	RECOMMENDATIONS	32

APPENDICES

		Page
A.	Summary of "Basic Principles of Acceptable Housing" from American Public Health Association Program Area Committee on Housing and Health	35
B.	Notes on Recent Reports Concerning Housing in Toronto ...	37
	I) "The Housing Gap: Deficiencies in Appropriate Housing for Ex-Psychiatric Patients".....	37
	II) "The More Efficient Residential Use of Properties in the City, Including Promotion of More Affordable Housing".....	39
	III) "People Without Homes: A Permanent Emergency".....	41
	IV) "No Place to Go, A Study of Homelessness in Metropolitan Toronto: Characteristics, Trends and Potential Solutions".....	42
	V) "Metropolitan Toronto Task Force on Housing for Low Income Single People".....	44
	VI) "Metropolitan Toronto Assisted Housing Study: Part 1: Determination of the Need for Assisted Housing".....	46
	VII) "A New Housing Agenda for Metropolitan Toronto"....	47
	VIII) "The Final Report of the Mayor's Action Task Force on Discharged Psychiatric Patients".....	49
C.	Recommendations of the Interdepartmental Task Force on Affordable Housing - Nov. 7, 1983.....	51
REFERENCES		55

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Report prepared by:

Dr. Joan Campbell
Investigative Researcher
Community Health Protection Section

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EXECUTIVE SUMMARY

This report is an exploration of the relationship between housing and health in Toronto. The study was initiated by the Department of Public Health Social Environment Work Group in response to growing concern in Toronto about the crisis in affordable housing. This report is also a response to the directive established in previous reports - Public Health in the 1980's and the Departmental Programs Policy Paper - for the Department of Public Health to adopt preventive health approaches by addressing critical social and environmental problems and their health implications.

The report sets out to achieve four goals: 1) to document the nature and extent of the affordable housing crisis in Toronto; 2) to identify potential relationships between housing and health (with reference to the research literature); 3) to identify existing and potential roles for the Department of Public Health in housing issues; and 4) to recommend short- and long-term strategies for dealing with the affordable housing crisis.

Some indicators of Toronto's affordable housing crisis are:

- In 1982, 3,400 people were estimated to be without permanent homes in Metro Toronto.
- It is estimated that 35,000 family households in Metro Toronto are in need of housing assistance.
- In May, 1984 there were 12,000 people on the waiting list for subsidized housing with Cityhome.
- Fewer than 40% of the 107,000 apartment units in the City of Toronto are unequivocably available for rental by families with children.

While adequate accommodation is not the sole solution to health problems among Toronto's poor, being homeless or living in unaffordable or substandard housing makes it difficult, if not impossible, to engage in many practices that promote health. Moreover, inadequate housing conditions foster stress which lowers physical resistance to disease and exacerbates pre-existing emotional strains.

From the point of view of the Department of Public Health, problems of inadequate housing in Toronto can be characterized as having to do with unaffordability, physical deterioration and homelessness. Each of these conditions may have adverse health consequences; unaffordable housing may be associated with

malnourishment, substandard housing and crowding with diminished mental and physical well-being, and homelessness with disorientation and stress-related illnesses. All of these conditions have their roots in poverty.

Data on the health status of Toronto's poor, especially those who are inadequately housed, are unsatisfactory. Therefore, we are unable to document sufficiently the impact of housing on health in the City of Toronto. Nevertheless, we can speculate about which segments of the population are likely to be inadequately housed and vulnerable to the stressful effects of inadequate housing on the basis of available data and research conducted elsewhere.

At greatest risk are those in the lowest income groups, especially the unemployed. In Toronto the neediest group in terms of income and unemployment is single-parent families (excluding those who already receive housing assistance), nevertheless all categories of poor and unemployed persons experience a heavy burden of risk associated with both inadequate housing and ill-health. Children, in particular, are vulnerable to direct and indirect health effects of inadequate housing. Senior citizens also are at great risk, both for direct impacts on health and for premature institutionalization.

Toronto governments, both City and Metro, have demonstrated a commitment to address the local crisis in affordable housing through recent initiatives such as establishment of the Metro Singles Housing Corporation, recommendations by the City's Interdepartmental Task Force on Affordable Housing that the City Zoning By-law be relaxed to permit intensified use of existing properties, and enactment by the City of a by-law to impede demolitions of existing housing stock.

The Department of Public Health has ongoing involvement in housing concerns through advocacy, direct service to clients with housing problems, responses to sanitation complaints, and inspection of hostels, among other things.

Public health professionals have a mandate to protect community health and promote wellness. This mandate includes developing preventive health policies and implementing them. Moreover an important role for public health practitioners is to advocate for broader social policies that protect and promote public health. Good housing policy is good preventive health policy. Thus, in addition to other efforts aimed at alleviating health impacts of housing, public health practitioners have a role to play in demonstrating to policy makers at all levels that housing affects health. To carry out this role effectively, public health practitioners must become more involved in four areas:

- research - to document the health outcomes of inadequate housing;

- advocacy - to ensure that the policy formulation process is well-informed;

- planning and implementation - to assist in utilization of health data for implementation of housing policies; and

- community development - to ensure that communities have the resources to represent their needs in the process of policy development, planning and implementation.

RECOMMENDATIONS:

Research

1. That the Board of Health endorse the Medical Officer of Health's monitoring the impact of inadequate housing on the health of Torontonians, so that future public health housing policies can be targeted on the basis of health risks associated with inadequate housing. This should include an inventory of current housing information resources from the Commissioners of Housing, Buildings and Inspections, Planning and Development and the Medical Officer of Health.

2. That the Board of Health forward this report to the provincial Minister of Municipal Affairs and Housing for Ontario and the federal Minister responsible for Canada Mortgage and Housing Corporation, with a request that they increase spending for municipal non-profit and non-profit cooperative housing in their respective jurisdictions; and similarly that the Board use future research on housing and health undertaken at its request to advocate for additional social housing spending.

Advocacy

3. That the Board of Health endorse the following recommendations concerning income assistance from the Metro Toronto Task Force on Housing for Low-Income Single People Final Report (adopted by Metro Council March 28, 1984) and communicate its support to the Ministry of Community Services and the Metro Community Services Department.

   "It is, therefore, recommended that:

"17. The Ministry of Community and Social Services increase the shelter subsidy portion of the General Welfare Assistance rate for singles living in private rental accommodation.

"18. The Ministry of Community and Social Services revise the calculation of the shelter subsidy portion of GWA rates to reflect the cost of private sector rents in large urban centres.

"19. The Ministry of Community and Social Services simplify the existing rate schedules relating to accommodation type, regardless of whether the units are self-contained or not, such that they reflect real rental costs.

"21. The Ministry of Community and Social Services increase to the equivalent of 8 hours per week at minimum wage, the amount of monthly income which GWA recipients may earn without penalty."

4. That the Board of Health endorse the recommendations of the Interdepartmental Task Force on Affordable Housing Report of November 7, 1983 (see Appendix C) and communicate its support to the Land Use Committee for relaxing the Zoning By-law to encourage intensified use of existing properties.

5. That the Board of Health endorse the (July 19, 1984) motion of the Neighbourhoods Committee to review City By-law 459-76 concerning adult-only rentals, and communicate its support of this action to City Council.

6. That the Board of Health encourage City Council to pursue a policy of liberal application of the Demolition Control By-law as a means of discouraging landlords and/or developers from unconditionally depleting the City's stock of affordable housing.

Planning

7. That the Board of Health request City Council to have the Medical Officer of Health or his designate represented on all interdepartmental committees and task forces, dealing with housing policies (e.g., Interdepartmental Task Force on Affordable Housing; Alternative Housing Sub-Committee of Neighbourhoods Committee, etc.).

8) That the Board of Health request the Medical Officer of Health and the Commissioner of Housing to report on potential innovative housing arrangements for senior citizens and

single-parent families who are ineligible for or unable to obtain assisted housing, and to include a review of successful innovations that have been implemented elsewhere in Canada.

9. That the Board of Health request the Commissioner of Buildings and Inspections and the Medical Officer of Health to undertake a review of the Housing By-law and its enforcement and report their findings to the Board within one year.

10. That the Board of Health request the Commissioner of Planning and Development to undertake a review of definitions of boarding, lodging and rooming houses in City by-laws, with a view to amending relevant by-laws by simplifying and standardizing these definitions to facilitate development of an inspection program under the Health Protection and Promotion Act.

Community Development

11. That the Board of Health reaffirm the importance of community development as a preventive health strategy by endorsing the involvement of public health staff and resources in assisting community groups who wish to take an active role in solving their housing problems (e.g., provide consultation services for grant writing, promotional activities, coalition building, cooperative, non-chemical approaches to pest management, etc.).

HOUSING AND HEALTH: PUBLIC HEALTH IMPLICATIONS OF THE HOUSING CRISIS IN TORONTO

1. INTRODUCTION

In recent years, the Board of Health for the City of Toronto has built a strong philosophical and policy foundation for addressing the impacts of social and environmental conditions on the health of Torontonians. Their position is based on recognition of the fact that health is "...a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (1). This position is embodied in three key documents: Public Health in the 1980's, (2) The Unequal Society: A Challenge to Public Health, (3) and Departmental Programs Policy Paper (4).

Each of these reports emphasizes the relationships between social and environmental factors and human health. Public Health in the 1980's is a policy blueprint calling for a shift in focus away from treatment of individuals to preventive approaches to health aimed at social and environmental processes and structures. The Unequal Society: A Challenge to Public Health examines the relationships between poverty and health in Toronto, and similarly recommends that public health practitioners adopt a "socio-environmental" approach by making social systems the target of research, advocacy, education and change efforts. In the same manner, the Departmental Programs Policy Paper, in laying out a framework for Departmental programs, reiterates the need for multifaceted, preventive approaches to public health planning and programming.

These reports each deal with a broad spectrum of issues including unemployment, housing, nutrition, environmental pollution, etc. In the spring of 1983 the Social Environment Work Group, a subcommittee of the Community Preventive Health Program Committee of the Department of Public Health, undertook to assign priorities to issues addressed in these reports, and to begin dealing with individual issues. Three priority issues emerged: inadequate housing, hunger and unemployment.

Housing and Health: Public Health Implications of the Housing Crisis in Toronto is an exploration of the relationship between housing and health. The three documents mentioned above were taken as departure points for this report, which follows the philosophy of health embodied by those reports. The goals of the present report are as follows:

1) to document the nature and extent of the affordable housing crisis in Toronto.

2) to identify potential relationships between housing and health (with reference to the research literature).

3) to identify existing and potential roles for the Department of Public Health in housing issues.

4) to recommend short and long-term strategies for dealing with the affordable housing crisis.

It is important to keep in mind that housing is one of a constellation of influences on the health of our citizens. Improvements in housing conditions in isolation from other necessary socio-environmental changes will have limited benefits to health. Thus, to put this report in context, the reader should have some familiarity with previously mentioned reports and should consider this report in conjunction with the Access to Nutritious Food Report (Local Board of Health, May 22, 1984) and forthcoming reports to the Board on unemployment and health and multicultural health policy.

1.1 Toronto's Affordable Housing Crisis

It is not surprising that the Department of Public Health, as other service agencies, is feeling the impact of problems with inadequate housing in Toronto. The following facts illustrate the magnitude of the crisis:

- In 1982 a Metropolitan Toronto joint Planning Department and Community Services Department study estimated that, at a minimum, 3,400 persons were without permanent homes in Metro Toronto. 30% of these homeless individuals were 18-24 years old, 17% were under 18 years. 13% were women with children and 15% women without children. Approximately 33% came from within the City of Toronto (5).

- There are 1,900 hostel beds in Metro Toronto.

- A Metropolitan Toronto Planning Department study estimated in April, 1983 that 76,000 tenant households in Metro Toronto are in need of housing assistance, (i.e., subsidized housing) of which 35,000 are families with children (6). More recently, the Social Planning Council of Metropolitan Toronto has revised these estimates upwards to 110,000 (7).

- According to estimates of the Social Planning Council, a single adult living on General Welfare Assistance in Metro Toronto will have, on average, between $39.00 and $76.00 per month to live on after meeting shelter costs, depending upon monthly income and cost of rent.

- For 1984 the City of Toronto Housing Corporation (Cityhome) had expected an allocation of between 170 and 300 non-profit housing units from Canada Mortgage and Housing Corporation (CMHC) through the Minister of Municipal Affairs and Housing for Ontario. Of the 900 units allocated by the provincial minister in January, no units were allotted to the City of Toronto or surrounding municipalities in Metro Toronto. In March, 246 units were allocated to the City of Toronto on the condition that Cityhome adopt the Ontario Housing Corporation system of giving priority to the neediest families on the basis of a point-rating system.

- As of May 1984 there were 12,000 people on the waiting list for subsidized housing with Cityhome.

The causes of the crisis in affordable housing, which the Social Planning Council refers to as a "permanent emergency", are complex. Worldwide, national, regional and local economic and political forces all have contributed to a severe imbalance between supply and demand in housing, resulting in high rents and a dearth of affordable housing in Toronto. This imbalance has had the greatest impact on low-income groups who already are hard-hit by the economic recession.

Associations between poverty and ill-health were documented in The Unequal Society: A Challenge to Public Health which reviewed evidence showing that in our society it is the poor who suffer most from economic downturns. People in the lowest income strata are less healthy to begin with than the well-to-do, and in times of economic restraint they are the ones most likely to be laid off work (38, 45). Unemployment has been linked with a variety of health outcomes including alcoholism, increased hospital admissions, heart disease, family violence and suicide. Additionally, being poor means increased likelihood of occupational accidents and illness, inadequate nutrition, lack of adequate child care options, greater exposure to crowded, unsanitary and unsafe conditions at home, a much higher likelihood of being old and alone, and general lack of access to resources, choices, and supports for a healthy lifestyle.

That adequate housing is a necessary condition for a healthy life is a fundamental public health principle (8). The concept of adequate housing goes beyond the simple notion of a physical

structure that meets certain standards of acceptability. Ideally, in addition to providing shelter, housing should support needs associated with physical, psychological and social well-being to be considered adequate for a healthy life. Supportive elements necessary for healthful housing include: design features promoting security, proximity to transportation, services and recreational spaces (the latter is especially important for children), opportunities for social contact with persons both similar and dissimilar to oneself, opportunities for visual and acoustical privacy, and availability/accessibility of a network of services addressing a variety of needs (e.g., home care/visitors for senior citizens, child care for families, aftercare and crisis intervention for ex-psychiatric patients).

While adequate accomodation is not the sole solution to health problems among Toronto's poor, being homeless or living in substandard housing makes it difficult, perhaps impossible, to engage in many practices that promote health. Moreover, inadequate housing conditions foster stress which lowers physical resistance to disease and exacerbates pre-existing emotional strains. The remainder of this report will argue that adequate housing is a key factor in prevention of illness and promotion of health.

2. HOUSING AS A HEALTH ISSUE

2.1 Department of Public Health Experiences with Inadequate Housing

It has become increasingly apparent to the Department of Public Health that inadequate housing in Toronto is a growing health concern. For example, a recent survey of 72 public health nurses discovered that a third of the staff nurses who responded find that 20 to 80 percent of their clients are experiencing housing problems. Typical examples of cases that public health nurses encounter are:

- a mother with three children living in a small one-room apartment that is inadequately heated.

- a woman who is chronically mentally ill living in an unheated back porch - she uses a hot-plate for warmth.

- a mother and her teenage daughter paying $360.00 out of a $425.00 monthly income for a third floor flat with two bedrooms and a kitchen that has no refrigerator or stove; the bathroom is on the second floor; heating is inadequate.

According to survey results the number one housing problem for nurses' clients is unaffordability, with substandard physical conditions and unavailability of appropriate housing following closely behind. The majority of clients live in private rental accommodation and are either unemployed or part of the "working poor". Those with the greatest housing need are single-parent families and single adults without dependent children. Most nurses felt that inadequate housing interferes with provision of effective nursing care. They perceived that inadequate housing had adverse effects on the mental and physical health of their clients.

Public health inspectors also are witnessing the impact of the housing crisis, particularly in the city core where they have watched the ranks of the "street people" swell as hundreds of former rooming houses are "deconverted" into luxury accommodations. Inspectors report that this displacement of low-income single persons has resulted not only in the phenomenon of homelessness, with increased usage of emergency shelters and consequent rises in infectious diseases, but also in overburdening of the few rooming houses still in existence. Inspectors are frequently called into rooming houses in response to complaints of overcrowding, infestations of pests and vermin, proliferation of garbage, faulty sewerage and other conditions associated with

trying to stretch physical and human resources beyond their limits.

In addition to rooming house complaints, inspectors often are called upon to respond to sanitation complaints in other multiple occupancy dwellings. In 1981, for example, the Department of Public Health Annual Statement reported that public health inspectors received more complaints about housing (rooming houses and other) than any other single issue (49%). Moreover, public health inspection data reflect only a certain proportion of problems that are reported. The City of Toronto Housing By-law, which contains standards for everything from safe stairways to electrical wiring to crowding and provision of hot water, is administered by the Commissioner of Buildings and Inspections and his staff. (See Section 2.3.2.1). The Buildings and Inspections Department keeps independent records of responses to complaints under this By-law.

2.2 Groups At Risk

There are three principal aspects of housing inadequacy that influence health among vulnerable Torontonians. They are 1) unaffordability, 2) physical deterioration and 3) homelessness. Information about each of these conditions and its influence on health will be examined in a later section to identify potential relationships between housing and health in Toronto.

In public health practice, determination of who is most in need of preventive interventions usually is based on vulnerability to disease. Vulnerability is typically established by discovering "risk factors" associated with certain diseases (e.g., high blood pressure and heart disease; smoking and lung cancer) and identifying individuals or groups in the population who display some or all of these risk factors. Once groups at risk have been identified, preventive programs can be designed to reduce or eliminate risk factors and to promote health.

Groups who are identified as needy in this manner may not necessarily correspond with groups that have been identified as needy by other methods. In terms of needs for affordable housing, recent reports have identified low-income, non-senior singles as the group most needing new housing assistance programs (e.g., 39,40). Low-income singles have been targeted on the basis of their ineligibility for housing assistance programs that apply to families and singles over age 65. In Metro Toronto at present there is a large unmet need for small affordable rental units for non-senior singles. Low-income, non-senior singles may not experience the greatest health risk, however, in relation to housing.

The principal risk factor associated with suffering ill effects from unaffordable housing, substandard housing and/or homelessness is poverty. Poverty is associated with increased illness and a shorter lifespan in Canada (38). Poverty also is associated with inadequate housing. Chances of experiencing one or all of the three previously mentioned aspects of housing inadequacy increase drastically as income declines. According to the Metro Toronto Assisted Housing Study the median incomes of single parent families on waiting lists for Metro Toronto Housing Authority, Metro Toronto Housing Company and Cityhome are $8,300, $7,500 and $7,200 respectively; median incomes for two-parent families on the waiting lists are $13,000, $11,900 and $11,500. On the Cityhome waiting list, 72.4% of two-parent families and 93.5% of one-parent families have incomes less than $15,000. It is probable that most of these households are experiencing inadequate housing.

Another risk factor which increases vulnerability to housing inadequacy is unemployment. Like poverty, which is an inevitable consequence of prolonged unemployment, unemployment is independently associated with a growing number of adverse health outcomes including alcoholism, suicide, infant mortality, depression, mental hospital admission, death due to cirrhosis of the liver and heart disease (41,42,43,44). Those at greatest risk from stresses related to their economic plight - unemployment and poverty - are also the ones most likely to be inadequately housed. Furthermore, because of the severe emotional and physical impact of unemployment, effects of life stresses like inadequate housing are often exacerbated and efforts to cope become limited and ineffective (45).

There is one group that is often forgotten as a major victim of poverty and unemployment, i.e., children. Of all groups likely to suffer ill-effects, direct or indirect, of being inadequately housed, children of the poor and unemployed are probably the most vulnerable. Children's health is adversely affected by physical crowding, by lack of privacy and by lack of recreational space. Sadly, children are often targets for their parents' frustrations and emotional responses to economic stress; children are the victims of neglect and malnourishment when parents can't make a pittance stretch far enough to cover rent, and a babysitter and a nourishing diet. In 1979, CMHC estimated that between half a million and a million children in Canada were inadequately housed (46). Given economic trends since that time we can be sure that the number today is much, much higher.

A final risk factor that increases the likelihood of being inadequately housed in Toronto is disability, either physical disability by virtue of limited mobility and/or age, or mental disability associated with having been hospitalized for

psychiatric illness. The desperate housing experiences of ex-psychiatric patients in Toronto have been the subject of intensive study recently, resulting in a report from the Mayor's Action Task Force on Discharged Psychiatric Patients (9). The Task Force Report proposes an innovative solution to the housing plight of ex-patients, involving contract aftercare being provided in licensed rooming houses. Until this recommendation is implemented, mental disability will continue to be a serious risk factor for inadequate housing in Toronto.

Physical disability is a risk factor for inadequate housing in Toronto because it also is associated with poverty and often with either chronic custodial care, or, occasionally, exploitation in substandard accommodations at the hands of unscrupulous landlords in the private rental market (49).

A recent Department of Public Health report on the plight of senior citizens in Toronto (47) emphasizes that housing problems for senior citizens - who constitute a rapidly increasing percentage of the population - are especially acute. Not only do they have affordability and physical quality problems in housing, but there is a critical lack of home care support services which would enable many seniors to live with dignity and relative independence on their own (58). In the absence of such services, many seniors are at risk of premature institutionalization.

2.3 Dimensions of Housing Inadequacy

Quantitative data on health effects of housing among low-income Torontonians are difficult to find. We are just beginning to consider how to measure the health status of Toronto's poor. Thus, in the following discussion on the relationship between health and housing affordability and physical quality and homelessness, references to research data will be based on studies conducted elsewhere, where information is lacking from the City of Toronto.

2.3.1 Affordability

For housing to be "affordable" means that household shelter costs should be within a range that makes it possible also to purchase other necessary goods and services after shelter costs are met.

Affordability usually is defined statistically, in relation to household income. One common manner of determining housing affordability is as a fixed percentage of household income. The upper limit of affordability for housing typically is taken to be 25-30% of gross household income (6). Thus, when housing cost

(rent and utilities) is more than 30% of income, a household is experiencing an affordability problem.

Another method of determining housing affordability is the "residual income" approach, which subtracts housing costs from net household income and compares the remainder, i.e., residual, to a standard income needed to cover non-housing costs for a given household size and composition. This approach was used by the Metropolitan Toronto Planning Department in their Assisted Housing Study to avoid certain shortcomings of the fixed percentage approach: a) that it does not take account of variations in non-housing expenditures across different size households; and b) that it does not reflect relatively fixed non-housing costs, such as transportation, food, and child-care, which consume greater percentages of gross income as income declines (6).

The latter point is critical for understanding the impact of unaffordable housing on low-income families: when a household has an income that is below "poverty line" and costs of shelter and subsistence are relatively invariant and together greater than household income, then an adjustment must be made. Either less costly shelter must be found so that a higher proportion of income can be spent on subsistence; or, if less expensive shelter is unavailable (as is the case for thousands of households on waiting lists for assisted housing in Toronto), then expenditures on other basic needs must be sacrificed.

The Metropolitan Planning Department's Assisted Housing Study, using the residual income method of determining need for affordable housing found that families with children have the greatest magnitude of need for housing assistance and single-parent families have the most critical need of any group (which confirms observations of public health nurses) (6). Through statistical methods the study determined that many single parent families in Metro Toronto are doing without basic necessities in order to pay shelter costs in the private rental market. (Single parent families are much more likely than others to apply for assisted housing: the study estimated that 40-45% of single parent tenant households in Metro Toronto live in rent-geared-to-income units). This conclusion was based on data showing that the average monthly budget shortfall (adjusted for family size, employment status and children's ages - based on Social Planning Council of Metropolitan Toronto Guide to Family Budgeting, 1981) after housing expenses for a single parent family in Metropolitan Toronto is $543. Nearly a third of the single parent families surveyed were $800 short of what they needed for non-housing costs - transportation, food, clothing and child-care.

The experience of many single parents in Toronto as well as others living in unaffordable housing is a situation of severe deprivation induced by high housing costs. People are going hungry and/or undernourished in Toronto because of the paucity of low-cost rental housing (50). Individuals must make choices between hiring a babysitter and purchasing a transit ticket to go out searching for a job or cheaper housing (51). Children are being kept home from school for lack of winter boots and warm coats (52). Malnourishment, child neglect, depression, stress and fatigue leading to physical illness are some of the potential health outcomes resulting from being poor and paying (unassisted) rent in Toronto. The full range of health effects associated with unaffordable housing in Toronto needs to be documented in order to strengthen advocacy efforts and target preventive health programs.

Appropriate Housing: An aspect of the unaffordability issue that is often overlooked is availability of appropriate housing. It is axiomatic that persons of limited financial means have few choices. Because the supply of inexpensive rental accommodations in Toronto is greatly exceeded by demand, competition for existing units is fierce and most people must settle for what they can get or suffer severe deprivation to obtain what they need. Among low-income groups who experience difficulty in Toronto obtaining affordable housing appropriate to their special needs are:

- discharged psychiatric patients, many of whom require supportive housing to facilitate reintegration into the community but instead end up alone in overcrowded rooming houses or wandering the streets, eventually landing back in their former institutions (9);

- frail senior citizens who may wish to live independently but require supportive, barrier-free environments - unchosen early institutionalization or solitary confinement in non-supportive housing often begins a downward emotional spiral of frustration, depression and rapid physical deterioration . (10);

- physically disabled adults, most of whom wish to live independently but require varying levels of support and barrier-free living space - unavailability of appropriately designed housing with attendant care means spending life in chronic-care facilities for many disabled persons, a situation that is at odds with individuals' needs and aspirations and an explicit government policy of deinstitutionalization;

- low-income families with children, especially single-parent families, who find that landlords of "affordable" rental accommodations frequently do not rent to families with

children - a situation maintained by municipal by-laws permitting "adult only" rentals. According to City of Toronto Planning and Development Department figures, fewer than 40% of apartment units in the City of Toronto are positively available for rent to families with children (i.e., subject to City By-law 459-76, the "adult only" by-law). Child welfare workers in Metro Toronto report a growing phenomenon of families separating and children being placed in foster care as a direct result of housing problems (11, 56).

There are approximately 54,000 assisted housing rental units in Metropolitan Toronto, approximately 19,000 of which are in the City of Toronto (40). Estimates of the number of additional households needing assisted housing vary; but whether the total is 91,000 as estimated by the Metro Planning Department or 110,000 as calculated by the Social Planning Council, there is no question that an alarming number of low-income households in Metro Toronto are spending their meagre resources on housing they can't afford and consequently doing without goods and services necessary for a healthy life.

2.3.2 Physical Quality

In 1969 the American Public Health Association Program Area Committee on Housing and Health developed "Basic Principles of Healthful Housing" (8). These principles established health requirements to be applied as standards for housing. The principles were organized around three target areas: 1) human factors; 2) sanitation and maintenance; and 3) safety and injury (See Appendix A for a summary of these principles).

In 1974 the Ontario Ministry of Health produced a set of Guidelines for Residential Housing (12) which explicitly recognized the influence of housing quality on "physical, mental and social well-being". These Guidelines deal with requirements for space, heating, water supply and sewage, ventilation and lighting, insects and rodents, safety, basic equipment and more.

Crowding: A great deal of research has been conducted to determine the impact of physical quality of housing on human health and well-being. Much of this research has focussed on density and crowding. Reviews of research literature on housing density and health conclude that evidence of adverse effects of housing density is equivocal (13,14,15,16,17,18). A variety of health problems from pneumonia (19) and tuberculosis (20,21,22) to increased infant mortality, suicides (23,24), mental hospital admissions (25) and cancer deaths (26) have been statistically associated with overcrowded living conditions.

The correlational research studies upon which these findings are based, however, do not establish causal relationships between crowded living and poor health. Because many of these studies base analyses on aggregates (e.g., census tracts) rather than individuals, it is often impossible to know if those persons suffering health effects are the same ones living in crowded quarters. Moreover, observed statistical associations could be interpreted as meaning that sick people tend to find inadequate housing to live in, rather than that crowded housing causes illness among its occupants. Many studies on housing and health do not separate the possible influence of housing from a number of other factors that may be causally related to ill health - low income, poor medical care, unemployment, poor nutrition.

A study of urban crowding that avoided some of these pitfalls was conducted in Toronto in the 1970's (27,28). This study involved personal interviews with and medical examinations of several hundred Toronto families. One aspect of the study focussed on the influence of housing quality on mental and physical health of women. Features of the home environment selected for study were: space and privacy; major and minor structural deficiencies; and the non-structural deficiencies of cold, noise and pests. The study's authors, Duvall and Booth, found that lack of privacy and space problems were significantly related to symptoms of psychiatric impairment and use of sedative-hypnotic drugs.

Using the same data, Booth (27) found that children living in crowded households tended to be shorter and weigh less than their uncrowded counterparts, and to be sick more often. Additionally, children from crowded homes tended to be slightly behind their age peers in terms of school achievement. In a different study, also in Toronto, Michelson (29) observed that school achievement scores were related to neighbourhood density, but not to household density. Interestingly, Michelson noticed that school children who had "functional privacy" at home - i.e., a space "devoted to quiet pursuits" for doing homework - scored higher on achievement scores than children who had to share space that was used for other noise-making activities.

What can be concluded from research on housing density and crowding is that density per se is at best weakly related to physical health of adults. For women, a stronger relationship exists between emotional health and lack of space and privacy than for men. Children seem to be more vulnerable to high density than adults. Lack of space at home may be responsible for slowing down intellectual and physical/motor development. This seems to be particularly true when lack of space is associated with absence of functional privacy and/or living in high rise apartments (17, pp. 447-450).

It is important to remember that human factors related to inadequate housing involve more than residential crowding. We probably can find housing that is adequate on other dimensions of quality but is overcrowded. It is not surprising that few adverse health effects are found in such cases. (This underlines a major problem with most research on residential density, i.e., that other dimensions of housing quality are not taken into account). In addition, because individual and cultural variations in perceptions of crowding influence what is considered acceptable, overcrowded accommodation by itself may or may not constitute inadequate housing (31).

The Metropolitan Toronto Assisted Housing Study estimated that 7% of tenant households in Metro Toronto live in overcrowded conditions. Given such a low incidence and given that crowding per se is only weakly associated with health outcomes, residential crowding in and of itself is not a general concern in Toronto. Having said that, however, the Department of Public Health recognizes that crowding in rooming houses and emergency shelters, particularly in the downtown core, is a widespread problem; and we support initiatives such as the Metro Singles Housing Corporation to create permanent housing for low-income singles, relieving the burden on rooming houses and hostels.

Physical Deterioration: Among the conditions that are health and accident hazards and clearly characterize inadequate housing are: poor or non-existent temperature control and ventilation; lack of sanitary facilities for food preparation and storage, waste disposal and personal hygiene; poor illumination; rodent and/or insect infestation; faulty plumbing; structural hazards (e.g., absence of fire escape routes, faulty wiring, faulty heating equipment, cracked plaster, broken stairs, railings, etc.). Michelson notes that such conditions characterize housing that is "desperately inadequate" (17).

One way to evaluate the health effects of living in desperately inadequate housing is to look at the effects of relocation to better housing. Again we must refer to evidence gathered elsewhere. A classic study conducted in Baltimore compared 300 families who were rehoused from "slums" to public housing projects with 300 families who remained in slum housing (32). Families were interviewed approximately ten times over a period of three years. On a variety of morbidity and disability measures the members of the rehoused group were healthier up to 36 months after their move. Health improvements were most pronounced among rehoused youngsters, who had fewer and shorter illnesses and better school attendance and participation than children who were not rehoused. For those who moved, the most important improvements they perceived in housing were: less crowding,

better temperature control, better food and waste disposal sanitation, and absence of rodents.

As mentioned above, Duvall and Booth conducted research in Toronto on housing quality and health among women (28). The housing variables included in their study were: major structural deficiencies (e.g., sagging walls, holes in walls and floors, unsafe stairs); minor structural deficiencies (e.g., broken windows, small cracks, missing or old paint); and non-structural deficiencies (indoor temperature during the winter; noise which disturbed sleep, and presence of flies, cockroaches and/or rodents). They found that total disease incidence (as measured by physician's diagnosis), stress illnesses (e.g., hypertension, peptic ulcers, irritable colon), days spent sick in bed, and reproductive system disorders, all were associated significantly with housing quality factors. The authors concluded that the effects, while modest, demonstrated that poor quality housing contributes to ill health.

We do not have estimates of how many people in Toronto are living in desperately inadequate housing, much less how healthy they are. Nevertheless, in the past few years, the Buildings and Inspections Department reports spending up to $100,000 per year to rectify "urgent hazards" which landlords refuse to correct. Examples of such expenditures are payments to utility companies to reconnect and maintain hydro or gas heat during the winter, and payments to contractors for repairing structural faults that represent imminent accident or health hazards. For the first six months of 1984, the City had already spent $92,000 to eliminate such hazards. (These expenditures are usually recovered through property liens or property taxation of landlords.)

Both the Department of Public Health and the Buildings and Inspections Department keep records on complaints about housing. For the Department of Public Health, the majority of complaints concern sanitation issues. It is difficult to know the extent to which complaint data are representative. According to health inspectors, chronic problem addresses constitute a large number of cases. Relatively "invisible" substandard housing that never comes to the attention of City officials because tenants fear reprisals if they complain is believed by some to be widespread. The Metropolitan Toronto Assisted Housing Study estimated that 16% of tenant households live in physically inadequate housing in Metropolitan Toronto (lacking or having to share kitchen or bathroom facilities, or needing one or more major repairs). Nevertheless, senior building and planning officials for the City contend that in comparison with other major North American cities, the overall quality of Toronto's housing stock is good, and that desperately inadequate housing is relatively rare in our city.

Because of a huge unfulfilled demand for affordable housing in Toronto it is likely that many people in need are settling for whatever they can get regardless of physical quality (e.g., buildings inspectors report a great increase in illegal basement use). It is also likely that many more people are living in substandard conditions which do not come to the attention of public health or housing inspectors because low-income tenants fear eviction if they complain. Such fears of eviction may be legitimate. A senior Buildings and Inspections Department official has indicated that a dramatic increase has occurred recently in the numbers of subpoenas served on building inspectors to appear on behalf of tenants at hearings convened under the Residential Tenancies Act. Hearings are usually convened to settle eviction disputes.

2.3.2.1 Housing By-law

The Housing By-Law (No. 73-68) and its amendments, together with the Rodent Control By-law (No. 17659) and its amendments govern the physical adequacy of multiple occupancy dwellings and lodging houses, and all "lands, building or structures", and all "rented or leased dwellings" respectively, in the City of Toronto. The Commissioner of Buildings and Inspections has a staff of 80 inspectors enforcing the Housing By-law. The Rodent Control By-law is enforced through the Medical Officer of Health by two rodent control specialist inspectors in each of the City's four Health Areas.

According to Ontario Ministry of Health 1974 Guidelines for Residential Housing,

> "Residential Housing, as the shelter for the family, is the core of (hu)man's environment and as such involves many aspects of environmental health concern. Water supplies, sewage and garbage disposal, spatial provisions, thermal conditions, ventilation, illumination, noise and accident-creating hazards are all aspects that can affect (hu)man's physical, mental and social well-being". (1974, p. 1) (Emphasis added)

These principles are consistent with public health goals of protecting and promoting health in the housing environment and they serve as an excellent basis for evaluating and regulating housing adequacy.

The Ministry of Health Guidelines were developed "to assist health agencies in the implementation of their housing programs" and were intended to be applied to the Ontario Public Health Act (recently replaced by the Health Protection and Promotion Act), its

regulations and related by-laws. The two municipal housing related by-laws mentioned above were not designated specifically under the Public Health Act, although the Medical Officer of Health administers the Rodent Control By-law. Nevertheless, the underlying objective of these by-laws is protection of public health. Indeed, the Housing By-law conforms to the Guidelines in many respects.

Although the City of Toronto Housing By-law has been improved recently through several amendments, there are still discrepancies between the Housing By-law and the Ministry of Health Guidelines, resulting in less-than-optimal standards for health protection and promotion in housing environments in Toronto. The inadequacies are mentioned briefly here to illustrate aspects of the Housing By-law that could be strengthened. The objective of this presentation is to draw attention to gaps in the Housing By-law as a first step in a new review process that will lead to further amendments to the By-law.

The major discrepancy between the Ministry of Health Guidelines and the Housing By-law concerns what is referred to in the Guidelines as "basic equipment" - refrigerator, stove, cupboard and counter space, suitable facilities for washing, bathing and laundering (Section 5). In terms of kitchen equipment the Housing By-law requires that refrigerators and stoves be provided only in rooming houses (Section 29 (7)) where kitchen facilities are used in common by the occupants. Owners of other multiple occupancy dwellings are required to provide only "...a suitable and convenient receptacle for the storage of food that has a capacity of not less than 4 cubic feet multiplied by the number of rooms in the dwelling used for sleeping purposes" (Section 26 (2)): refrigerators are not required. There are no requirements in the By-law for kitchen cupboard and counter space. As for bathing and laundering facilities, the By-law requires "...at least one bathtub or shower or combination of bathtub and shower that is ... served with hot and cold running water" (Section 25 (3)), but does not require laundry facilities.

If occupants of multiple occupancy dwelling units are expected to keep the homes in "...clean and sanitary condition" (Section 4 (4)) then they must be given the tools for adequate sanitation. Current provisions in the By-law for "basic equipment" are not commensurate with requirements that occupants keep their units clean. In addition to placing an unreasonable responsibility on residents of multiple occupancy dwellings, absence of "basic equipment" may constitute a health hazard by preventing adequate sanitation. Therefore, provision of basic equipment as recommended in Ministry of Health Guidelines - refrigerator,

stove, cupboard and counter space, and facilities for laundering - should be a requirement in the By-law.

Another gap in the Housing By-law concerns failure to recognize indoor air contaminants as a potential health hazard in residential environments. The By-law requires "adequate natural or artificial means of ventilation" for all habitable rooms, bathrooms, shower rooms and toilet rooms (Section 28 (5)). The Ministry of Health Guidelines go further, however, and define an "adequate ventilation rate" as 5 cubic feet per person per minute, and a "recommended" rate as 7.5 - 10 cubic feet per person per minute (Section 7). The Guidelines also specify an adequate number of air changes per hour by mechanical ventilation as 6 to 15 depending upon the type of room (e.g., 15 changes per hour for kitchens, 6 changes per hour for laundry rooms). (These figures compare with one change per hour required by the Housing By-law). Moreover, the Ministry of Health Guidelines note that when smoking is involved much greater amounts of fresh air are required, especially when there are many people sharing a space.

Attention to smoking as a factor in residential ventilation requirements is important because "sidestream" cigarette smoke is a hazardous air contaminant; as such it must be considered in establishing residential ventilation standards. Recognition of cigarette smoke as an indoor air contaminant is especially important for protecting human health in multiple occupancy dwellings (as opposed to single family) where a few individual smokers may contribute to contamination of air breathed by everyone, smokers and non-smokers alike. The more smokers there are, the more contaminated circulating air will be. Moreover, "sidestream" cigarette smoke is much more toxic than "mainstream" smoke inhaled by smokers (54). Assuming that smoking in one's own home is unlikely to be prohibited (nor could such a prohibition be enforced) a minimal requirement to protect the health of "involuntary" smokers in multiple unit residences would be effective ventilation.

Cigarette smoke is but one source of indoor air pollution. With growing recognition of the potential health hazards associated with indoor air contaminants, public health professionals are becoming concerned about residential and occupational exposures to indoor pollution. Thus, we would like to see improvements made in ventilation standards in the Housing By-law. Specifically we wish to see Ministry of Health definitions of adequate ventilation incorporated into the By-law.

Two provisions absent from the Housing By-law constitute important measures that should exist in all residential premises. These are "child-proof" latches on all windows and doors (a subject of

ongoing study by the Department of Buildings and Inspections), and adequate lighting in all public areas and entrances to buildings and individual dwelling units. Ministry of Health Guidelines for the latter specify illumination of not less than 10 foot-candles measured at any part of the floor or at the top of the tread (Section 1.8). The increased security of young children and adults, particularly women and seniors, should be ample justification for implementation of these measures.

The foregoing discussion has dealt with a few shortcomings in an otherwise satisfactory Housing By-law. Gaps in the By-law become apparent when it is compared with the Ministry of Health Guidelines for Residential Housing. We recommend that a review of the Housing By-Law be undertaken by the Commissioner of Buildings and Inspections, and the Medical Officer of Health.

2.3.3 Homelessness

Preceding sections have discussed unaffordability and described research on housing quality, demonstrating links between housing and health. For public health professionals these issues are critical aspects of the crisis in affordable housing. Equally critical is the matter of homelessness and its influence on health. Because the phenomenon of widespread homelessness is without precedent in North America since the Great Depression, this problem has not yet been the subject of formal research. Although we have estimates of the numbers of homeless in Toronto, and to some extent, their demographic profile, we have little sense of their health status.

The Metropolitan Toronto Planning Department's Assisted Housing Study estimated in 1982 that nearly 3,500 persons in Metropolitan Toronto were without permanent addresses (this estimate was considered to be low). Among Toronto's homeless, 41% of hostel users are under 25 years of age; 77% of them are men. Fifty-two percent of hostel users previously lived in rental units which were lost due to eviction or rent increases. Nearly 90% of hostel users either have no income or receive welfare. The largest increases in hostel users during the past few years have been among youth, ex-psychiatric patients and unemployed, willing-to-work persons.

At this point we can only speculate about the health consequences of homelessness. It is very likely that homelessness, particularly recent, involuntary homelessness affects both physical and mental health adversely (57). Extrapolation from research on involuntary relocation, suggests that unwanted, uncontrollable change in residential location can result in severe psychological deterioration and stress leading to physical and

mental illness (33,34,35). Most research on involuntary relocation has involved the elderly. Adverse effects of relocation are attributable to disruption of existing social networks and relationships when individuals are moved from one location to another (15,36). The common element in homelessness and involuntary relocation is absence of choice over where one lives.

Very few persons choose to be without a permanent home (57). Many of those who obtain temporary emergency shelter are probably only marginally better off than those who spend their nights in parking garages and doorways. Persons who recently have become homeless have a host of profound stresses to deal with, including: a) disruption of social environment, including loss of proximity/access to friends, acquaintances and familiar surroundings and the prospect of unchosen social interaction in hostels, soup kitchens, etc.; b) absence of privacy inherent in group living; c) lack of control over noise in group living situations; d) uncertainty and lack of control over where to live, where the next meal is coming from, etc.; e) ineligibility for welfare due to lack of a permanent address.

The relationship between stress and illness has been studied extensively by social and biomedical scientists. Research has shown that a variety of stress provoking events and conditions including noise, crowding, bereavement, job pressures, marital conflict, and joblessness, may adversely affect health. Among the physiological responses that have been measured as responses to stress are: increased blood pressure and heart rate, interference with immune system functioning, and increased secretion of stomach acids (37). Causal connections between stress and illness are not well understood. Nevertheless, factors such as availability of support networks and a sense of control over events in one's life may reduce otherwise adverse effects of stressful situations (60,61).

For those using emergency shelters, group shelters provide a vital service. Hostels are not intrinsically unhealthy. Many of them provide better accommodation than some of their clients are accustomed to. Nevertheless, because of their extreme burden of stress, the majority of emergency shelter users probably are not healthy, and will not become healthy living in hostels.

It is critical that the homeless, because of the extremity of their need, be targeted in preventive health efforts. In this regard, top priority must be given to providing permanent, affordable, user-supportive accommodation. At the same time it is important to discover more about the health status of homeless individuals and their non-housing needs - for example, the

variations of need among homeless youths, homeless women with children, and chronically homeless single men and women - in order to develop permanent housing options that are appropriate to these special groups and to provide adequate support services in the interim.

3. HOUSING INITIATIVES IN TORONTO

Toronto governments, both Metro and City, have demonstrated a commitment to address the local crisis in affordable housing through recent initiatives on a variety of fronts.

Advances have been made in addressing the issue of providing long-term affordable accommodation for the homeless, particularly for low-income, single adults who traditionally comprise the bulk of the "hard core" homeless. As a result of a Metropolitan Toronto task force on housing for low-income singles, the Metro Toronto Singles Housing Corporation has been established and promised funds by metropolitan and federal governments to provide affordable housing for low-income single adults.

On another front, a task force has been formed by the Metropolitan Toronto Council to study conditions in emergency hostels throughout Metropolitan Toronto. Recognizing that the need for emergency shelter will not diminish in the near future, we hope that this initiative will result in improved emergency accommodations in the short run.

In the City of Toronto, efforts are being made to influence supply of affordable housing through intensification of existing residential properties. The mechanism for intensified use of existing housing is the Zoning By-law. Reports from the Interdepartmental Task Force on Affordable Housing (39) recommended amendments to the Zoning By-law which would relax City control over use of residential properties with the aim of facilitating and encouraging additions of small rental units onto existing properties. This initiative could have added benefits in terms of employment. An economic study undertaken for the Ontario Ministry of Municipal Affairs and Housing in 1982 showed that housing renovation creates more jobs than construction of new housing (53).

In addition to influencing supply by means of the Zoning By-law (which will have a modest impact, at best, on the supply of affordable housing in Toronto), the City has a policy of identifying surplus, City-owned properties and transferring them, when feasible, to Cityhome for development as affordable housing. A recent report to the Neighbourhoods Committee from the Commissioner of Planning and Development (48) recommended that the Commissioners of Housing and City Property prepare a report on revised procedures for reporting on and transferring to Cityhome, municipally-owned sites, with the aim of clarifying and formalizing the process. We endorse this recommendation with the hope that it will lead to a more vigorous program of conversions of City-owned properties into affordable housing.

In terms of housing supply, City Council has moved in several instances recently to discourage conversion to condominiums or demolition of apartment buildings providing low to moderate rent accommodations. We applaud these actions and look forward to seeing the new Demolition Control By-law used liberally to limit loss of affordable housing through unconditional demolitions.

In addition to these efforts on the part of the City of Toronto to increase the supply of permanent, affordable housing to meet the needs of Toronto's homeless, Cityhome owns a number of rooming houses and sponsors two small-scale emergency shelters, one of them (at 30 St. Lawrence St.) in a former Department of Public Works office building.

Finally, the City is exploring solutions to the housing crisis. Through the Alternative Housing Sub-Committee of the Neighbourhoods Committee, the City is engaged in ongoing efforts to develop long-term housing alternatives for Toronto's "hard to house", low-income adults. In a different vein, City Council recently approved funding for a consultant's study of Toronto's housing shortage and possible solutions (59).

3.1 Role of the Department of Public Health

The groups described previously are among the most powerless individuals in our society. There is frequently little that they can do on their own to improve their housing conditions, either in terms of acquiring cheaper accommodation or making substandard housing more liveable. (Occasionally individual initiative, soap and water and a change in habits can improve an environment if one has the tools - e.g., hot water - and the energy). Public health professionals have participated actively in helping to alleviate some of the stresses of inadequate housing in Toronto. The ongoing involvement of the Department of Public Health in housing concerns will be described briefly in terms of affordability, physical quality and homelessness.

3.1.1 Unaffordability

Efforts of Department of Public Health staff to relieve some of the stresses associated with unaffordable housing have taken the form of advocacy, participation in coalitions and one-to-one efforts on behalf of the individuals in need.

- Mayor's Action Task Force on Discharged Psychiatric Patients: This report was prepared by Dr. Reva Gerstein at the request of the Mayor. The Department of Public Health worked with Dr. Gerstein to complete the report and anticipates being involved in implementation of the recommendations in the report.

- Food Advocacy Coalition of Toronto (FACT): This coalition of food providers and those concerned with food issues was organized by the Department of Public Health staff to act as a clearinghouse for information on access to food. As a result of this work, a report was written for the Board of Health, entitled Access to Nutritious Food, and a survey of food needs is being undertaken.

- Advocacy for healthy employment: A report is being prepared for the Board of Health dealing with unemployment and health in Toronto.

- East Toronto Housing Issues Committee (ETHIC): Department staff participate in this coalition of representatives from various health and social service organizations whose goal is to raise awareness about the housing crisis and its impact on their clientele in East Toronto.

- Efforts on behalf of individuals: Staff nurses frequently encounter clients with housing problems. As part of routine caregiving public health nurses make contact with housing registries and/or refer their clients; write reference letters for clients supporting their applications for public housing; and occasionally counsel tenants in disputes with landlords and intervene on their behalf with landlords.

3.1.2 Physical Deterioration

Staff of the Department of Public Health are also involved on a daily basis with complaints about substandard housing.

- Responses to sanitation complaints: Under the Health Protection and Promotion Act, the Medical Officer of Health (or his designates) is required to investigate complaints about residential premises. Public health inspectors frequently are called upon to investigate substandard housing conditions ranging from unclean premises and cockroach infestation to inadequate sanitary facilities, lack of hot water and backed-up sewage. Public health inspectors have the power to enforce remedial action to abate such nuisances; from time to time their intervention results in prosecution of landlords/occupants who are negligent in carrying out orders.

- Joint inspections under the Housing By-law: On occasion public health inspectors join with inspectors from the Buildings and Inspections Department to make inspections in response to complaints. Public health inspectors also make referrals to the Buildings and Inspections Department and, in turn, receive referrals from them.

- Health education activities: When appropriate, some public health nurses and public health inspectors attempt to instruct occupants about making changes in sanitation practices that may improve their living conditions.

- Inspections under the new Health Protection and Promotion Act: The Medical Officer of Health (or his designates) is required to undertake routine inspections of all boarding and lodging houses within the jurisdiction. This new mandate makes it important for municipalities to adopt a standard definition of "rooming house", "boarding house" and "lodging house" for the purpose of implementing this duty.

- Research: A study is underway to evaluate the effectiveness of an integrated pest management (IPM) approach to dealing with cockroaches. IPM is being assessed as a nonchemical method of pest control for Toronto.

3.1.3 Homelessness

Efforts of the Department of Public Health on behalf of homeless individuals have so far been limited.

- Inspection of hostels: On a routine basis, 30 hostels in the City of Toronto are inspected by public health inspectors to ensure adequate sanitation and to monitor the presence of infectious diseases.

4. SUMMARY AND CONCLUSIONS

From the point of view of the Department of Public Health, problems of inadequate housing in Toronto can be characterized as having to do with unaffordability, physical deterioration and homelessness. Each of these conditions may have adverse health consequences: unaffordable housing may be associated with malnourishment, substandard housing and crowding with diminished mental and physical well-being, and homelessness with disorientation and stress-related illnesses. All of these conditions have their roots in poverty.

Data on the health status of Toronto's poor, especially those who are inadequately housed, are unsatisfactory. Therefore we are unable to document satisfactorily the impact of housing on health in the City of Toronto. We can speculate, however, about which segments of the population are likely to be inadequately housed and vulnerable to the stressful effects of inadequate housing. At greatest risk are those in the lowest income groups, especially the unemployed. In Toronto, the neediest group in terms of income and unemployment are single-parent families (excluding those who already receive housing assistance); nevertheless, all categories of poor and unemployed persons experience a heavy burden of risk associated with both inadequate housing and ill health. Children, in particular, are vulnerable to direct and indirect health effects of inadequate housing. Senior citizens also are at great risk, both for direct impacts on health and for premature institutionalization.

The ongoing efforts of the Department of Public Health to address issues of inadequate housing have been described above, together with a variety of initiatives occurring at City and Metropolitan government levels in Toronto. Obviously there are limitations to what a municipal health department can accomplish in terms of improving housing. There are so many other pressing public health priorities, issues for which we have data to demonstrate clear, and often dramatic health outcomes, that to some it may be difficult to justify further involvement in inadequate housing - for which the health outcomes are not nearly so clear, nor perhaps as dramatic.

The purpose of this report has been to demonstrate that, far from avoiding further involvement, public health professionals must expand efforts to address the affordable housing crisis in Toronto. Inadequate housing, measured by unaffordability, physical deterioration or homelessness prevents people from being well in mind, body and spirit.

Inadequate housing is one of a constellation of socioenvironmental conditions - unemployment, lack of income, inadequate access to food, cultural alienation and discrimination, inadequate access to child care, etc., - that influence the health and well-being of Torontonians who are poor. Any one of these conditions by itself can be a source of frustration and stress that taxes an individual's ability to cope and increases vulnerability to illness. One researcher has labelled conditions of chronic scarcity and associated strains, constraints and deprivations, "endemic stress" (55).

Taken together, as the context of daily life for many people in Toronto, these conditions represent a burden of stress that is unmanageable more often than not. Frustration and despair, coupled with absence of necessary social supports, may move people to cope in the only ways familiar and/or available to them, ways that frequently make matters worse: substance abuse, violence, criminal activity, social withdrawal, etc.

It is therefore not surprising that the poor are less healthy and live shorter lives. Given what we do know about the health of people in Canada, public health professionals can begin to make some inroads in addressing health problems associated with poverty (as the Toronto Department of Public Health has done with its recent reports, The Unequal Society, the Access to Nutritious Food Report and the present report).

Given all that we do not know about the health status of Toronto's poor, however, it is clear that a need exists for more and better information on the effects of inadequate housing, unemployment, inadequate nutrition, etc., on the health of low-income Torontonians so that public health and other social policy interventions on their behalf can be maximally effective. We need to know about sources of income, expenditures for rent, food, clothing, etc., services available/utilized, housing quality and a variety of other factors, in addition to information concerning health status - illnesses, disabilities, lifestyle, etc., - to understand where changes must occur, both in the social system and in the lives of individuals, to achieve improvements in health. Reaching such an understanding requires a strong commitment to developing and maintaining excellent information resources.

As public health professionals we have a mandate to protect public health and promote wellness. Our mandate includes developing preventive health policies and implementing them. Moreover, an important role for public health practitioners is to advocate for broader social policies that protect and promote public health. Good housing policy is good preventive health policy. Thus, in addition to other efforts aimed at alleviating health impacts of

housing, public health practitioners have a role to play in demonstrating to policy makers at all levels that housing affects health. To carry out this role effectively, public health practitioners must become more involved in four areas:

- research - to document the health outcomes of inadequate housing;
- advocacy - to ensure that the policy formulation process is well-informed;
- planning and implementation - to assist in utilization of health data for implementation of housing policies; and
- community development - to ensure that communities have the resources to represent their needs in the process of policy development, planning and implementation.

If the Department of Public Health is to become more involved in the issue of inadequate housing in Toronto, the foregoing can be an effective course to follow in protecting health and promoting wellness. Our recommendations are organized accordingly.

5. RECOMMENDATIONS

Research

1. That the Board of Health endorse the Medical Officer of Health's monitoring the impact of inadequate housing on the health of low-income Torontonians, including the homeless, so that future community health and housing policies can be targeted on the basis of health risks associated with inadequate housing. This should include an inventory of current housing information resources from the Commissioners of Housing, Buildings and Inspections, Planning and Development and the Medical Officer of Health.

2. That the Board of Health forward this report to the provincial Minister of Municipal Affairs and Housing for Ontario and the federal Minister responsible for Canada Mortgage and Housing Corporation, with a request that they increase spending for municipal non-profit and non-profit cooperative housing in their respective jurisdictions; and, similarly that the Board use future research on housing and health undertaken at its request to advocate for additional social housing spending.

Advocacy

3. That the Board of Health endorse the following recommendations concerning income assistance from the Metro Toronto Task Force on Housing for Low-Income Single People Final Report (adopted by Metro Council March 28, 1984) and communicate its support to the Ministry of Community Services and the Metro Community Services Department.

"It is, therefore, recommended that:

"17. The Ministry of Community and Social Services increase the shelter subsidy portion of the General Welfare Assistance rate for singles living in private rental accommodation.

"18. The Ministry of Community and Social Services revise the calculation of the shelter subsidy portion of GWA rates to reflect the cost of private sector rents in large urban centres.

"19. The Ministry of Community and Social Services simplify the existing rate schedules relating to accommodation type, regardless of whether the units are self-contained or not, such that they reflect real rental costs.

"21. The Ministry of Community and Social Services increase to the equivalent of 8 hours per week at minimum wage, the amount of monthly income which GWA recipients may earn without penalty."

4. That the Board of Health endorse the recommendations of the Interdepartmental Task Force on Affordable Housing Report of November 7, 1983 (see Appendix C) and communicate its support to the Land Use Committee for relaxing the Zoning By-law to encourage intensified use of existing properties.

5. That the Board of Health endorse the (July 19, 1984) motion of the Neighbourhoods Committee to review City By-law 459-76 concerning adult-only rentals, and communicate its support of this action to City Council.

6. That the Board of Health encourage City Council to pursue a policy of liberal application of the Demolition Control By-law as a means of discouraging landlords and/or developers from unconditionally depleting the City's stock of affordable housing.

Planning

7. That the Board of Health request City Council to have the Medical Officer of Health or his designate represented on all interdepartmental committees and task forces, dealing with housing policies (e.g., Interdepartmental Task Force on Affordable Housing; Alternative Housing Sub-Committee of Neighbourhoods Committee, etc.).

8. That the Board of Health request the Medical Officer of Health and the Commissioner of Housing to report on potential innovative housing arrangements for senior citizens and single-parent families who are ineligible for or unable to obtain assisted housing, and to include a review of successful innovations that have been implemented elsewhere in Canada.

9. That the Board of Health request the Commissioner of Buildings and Inspections and the Medical Officer of Health to undertake a review of the Housing By-law and its enforcement and report their findings to the Board within one year.

10. That the Board of Health request the Commissioner of Planning and Development to undertake a review of definitions of boarding, lodging and rooming houses in City by-laws, with a view to amending relevant by-laws by simplifying and standardizing these definitions to facilitate development of an inspection program under the Health Protection and Promotion Act.

Community Development

11. That the Board of Health reaffirm the importance of community development as a preventive health strategy by endorsing the involvement of public health staff and resources in assisting community groups who wish to take an active role in solving their housing problems (e.g., provide consultation services for grant writing, promotional activities, coalition building, cooperative, non-chemical approaches to pest management, etc.).

Appendix A

Summary of "Basic Principles of Acceptable Housing" from American Public Health Association Program Area Committee on Housing and Health.

Human Factors

- Shelter against the elements.
- Maintenance of a thermal environment for optimal heat loss from the human body.
- Indoor air of acceptable quality.
- Daylight, sunlight and artificial illumination.
- In family units, facilities for sanitary storage, refrigeration, preparation and service of food.
- Adequate space, privacy and separation for normal family living.
- Opportunities for home recreation and social life.
- Protection from and control of noise from without and within housing structures.
- Design, materials and equipment which facilitate household tasks and functions without undue physical and mental fatigue.
- Design, facilities, surroundings and maintenance to produce a sense of well-being.

Sanitation & Maintenance

- Design, maintenance and equipment for sanitary maintenance of the dwelling and personal hygiene of the occupants.
- Water piping of approved, safe materials with installed, supplied fixtures which avoid introducing contamination.
- Adequate private sanitary toilet facilities within family units.
- Plumbing and drainage designed, installed and maintained so as to protect against leakage, stoppage or overflow and escape of odours.

- Facilities for sanitary disposal of food waste, storage of refuse, and sanitary maintenance of premises to reduce hazard of vermin and nuisances.

- Design for proper drainage of roofs, yards and premises.

- Design and maintenance to exclude and facilitate control of rodents and insects.

- Facilities for suitable storage of belongings.

- Program to assure maintenance of the structure, facilities and premises in good repair and in a safe and sanitary condition.

Safety and Injury Prevention

- Construction, design and materials of a quality that will withstand forces affecting structural stability.

- Construction, installation materials, arrangement, facilities and maintenance to minimize danger of explosions and fires or their spread.

- Design, arrangement and maintenance to facilitate ready escape, in case of fire or other emergency.

- Protection against all electrical hazards, including shocks and burns.

- Design, installation and maintenance of fuel-burning and heating equipment to minimize exposure to hazardous or undesirable products of combustion, fires or explosions, and to protect persons against being burned.

- Design, maintenance and arrangement of facilities, including lighting, to minimize hazards of falls, slipping and tripping.

- Facilities for safe and proper storage of drugs, insecticides, poisons, detergents and deleterious substances.

- Facilities and arrangements to promote security of the person and belongings.

Appendix B

Notes on Recent Reports Concerning Housing in Toronto

I) "THE HOUSING GAP: DEFICIENCIES IN APPROPRIATE HOUSING FOR EX-PSYCHIATRIC PATIENTS." Department of Public Health and Supportive Housing Coalition, May 1982

Summary

In May, 1982 a report was presented to the Local Board of Health which was a joint study by the Department of Public Health and the Supportive Housing Coalition. This report described the housing situation among ex-psychiatric patients, one of the largest groups of homeless individuals in the City of Toronto.

The purpose of the study was to examine the difficulties experienced by ex-psychiatric patients in obtaining appropriate housing. A variety of information gathering methods were employed, including interviews with personnel at Queen Street Mental Health Centre, Clarke Institute of Psychiatry, and psychiatric units at three general hospitals, with persons involved in locating housing for ex-psychiatric patients, general welfare assistance workers and family benefits administrators. Additionally, staff at 18 Metro hostels were surveyed and interviews were conducted with the staff of community services offering programs for ex-psychiatric patients.

Results were presented in terms of answers to eight key questions.

The study demonstrated that:

- 26% - 31% of patient discharges from the two mental health institutions had been delayed because of difficulties in finding appropriate housing in the community.

- 53% - 62% of discharged patients were assessed as requiring 24-hour supervision upon discharge.

- Specialized services for locating housing for ex-psychiatric patients reported that they could not find places for a substantial number of ex-psychiatric patients.

- 24% - 42% of discharged psychiatric patients had plans to live alone or had no plans at all.

- The survey of hostels indicated that 17% of adults in hostels on a particular day (April 6, 1982) had known psychiatric histories; 68% of persons "barred" from hostels (total = 366) were so designated for psychiatric reasons.

- More than 50% of discharged patients relied on welfare as their source of income.

- There was a consensus among hospital staff interviewed that housing problems played a part in causing ex-psychiatric patients to seek readmission.

The report made several recommendations, among them that the Ministry of Health provide funding to increase the number of supportive housing beds in Toronto; that the Ministry of Health establish a mechanism for coordination of support services to ex-psychiatric patients; that Metropolitan Toronto Community Services Department and Ministry of Community and Social Services make shelter supplements mandatory for ex-psychiatric patients; that Metropolitan Toronto Community Services Department remove the residency requirement for receiving general welfare assistance; that provincial and municipal governments fund enrichment services to complement the hostel programs; that data be maintained concerning psychiatric patients' housing status from prior to discharge until appropriate housing is obtained; and that the Department of Public Health work with appropriate community groups and agencies to seek implementation of the foregoing recommendations.

II) "THE MORE EFFICIENT RESIDENTIAL USE OF PROPERTIES IN THE CITY, INCLUDING PROMOTION OF MORE AFFORDABLE HOUSING", Interdepartmental Task Force on Affordable Housing, September 1982

Summary

On September 24, 1982 an Interdepartmental Task Force composed of the Commissioners of Planning and Development, Buildings and Inspections, and Housing, presented a report to the Neighbourhoods Committee of City Council on the promotion of more affordable housing in the City of Toronto.

This report focussed on the housing needs of smaller households, addressing the relationship between the social composition of the City, especially single adults under 65 years of age, and the physical composition, in particular the stock of small housing units. Exploring the economic plight of single adults at some length, the authors concluded that those under 60 are disadvantaged in terms of housing. Not only are they much more likely than families to have low incomes, they also are excluded from government housing assistance programs. Those who are able to find rental accommodation often must spend 75% or more of their meager incomes on rent.

The serious decline of rental housing stock in City of Toronto in recent years was thoroughly documented in this report. (For example, figures were presented which demonstrate that between 1979 and 1981, there was a 98% decrease in new rental units entering the private housing market. Between 1977 and 1981 average monthly rents for small housing units increased by 62% to 73%). The authors briefly described prevailing market forces that underlie the current housing shortage and concluded that it no longer pays developers to construct new small rental units or to create small units and rooms in existing houses. The authors referred to "policy context" to describe the housing responsibilities of municipal, provincial and federal governments. They pointed out that municipal involvement in housing policy is limited to land use regulations as specified by zoning by-laws. The report argued that the present Zoning By-Law in the City of Toronto is too restrictive, and recommended changes in the By-Law that would encourage intensified use of existing dwellings through conversion of single-family houses. Additionally, the authors took the position that the City should be prepared to intervene directly in the housing market by becoming a provider of affordable small housing units. This course of action would be most likely to occur if economic support was forthcoming from senior levels of government. Otherwise, additional municipal

expenditures or reallocation of existing City monies would be required.

III) "PEOPLE WITHOUT HOMES: A PERMANENT EMERGENCY." Social Planning Council of Metropolitan Toronto, January 1983

Summary

This report describes the shelter crisis in Toronto and makes the case that the problem is chronic - a permanent emergency. Among the factors underlying the emergency are exceptionally low rental vacancies, absence of new public housing construction, inadequate provincial social assistance/shelter subsidies, deconversion of multiple unit dwellings into single family units, restrictive public housing regulations and absence of adult residential facilities for special groups (e.g., ex-psychiatric patients).

The report suggests that a "coordinated set of strategies" is required to deal with the emergency, including review of municipal by-laws that restrict development of small dwelling units, review of provincial and federal policies concerning low-income housing units and rent subsidies, and removing the residency requirement for social assistance.

A case is made for improved emergency housing based on increased numbers of persons needing emergency accommodation, increased length of stays in hostels and changing profile of hostel users. The authors recommend that the role of hostels be redefined to clarify responsibilities for meeting long-term housing needs and providing support services. Several groups are identified as having distinct needs (e.g., unemployed men and women, families, homeless adolescents, ex-psychiatric patients, older adults).

Finally three issues are identified as being primary policy concerns requiring clarification and resolution: 1) role of emergency hostels; 2) access to hostels and quality of information; and 3) role of the voluntary sector.

The report concludes that provision of funds for long-term emergency services should not take the place of a publicly mandated program for planning to meet both short and long-term housing needs.

IV) "NO PLACE TO GO, A STUDY OF HOMELESSNESS IN METROPOLITAN TORONTO: CHARACTERISTICS, TRENDS AND POTENTIAL SOLUTIONS". Metropolitan Toronto Assisted Housing Study. Metropolitan Community Services Department and Metropolitan Planning Department, January 1983

Summary

This report is the first part of a larger Metropolitan Assisted Housing Study to identify the need for low-income assisted housing in Metro Toronto. The purpose of this study was to reach those with no permanent address (who would be missed by a mail-out survey which constituted the major focus of the Metro Assisted Housing Study) and identify their housing needs.

This report describes a "qualitative" study of homelessness. Interviews were conducted with staff at 24 emergency shelters, 12 social service agencies and 4 housing registries in Metro Toronto. These interviews were designed to elicit information on who clients are (i.e., demographic profile), increases and trends in homelessness and reasons for these, and suggestions for permanent housing solutions. Interviews were conducted in June 1982.

The most important findings of this study are as follows:

- In 1982, at a conservative estimate there were 3,400 homeless persons in Metro Toronto

- At the time of the survey, hostels were operating at more than full capacity with 1,556 residents for 1,529 available beds.

- Single men accounted for 77% of 1,556 hostel users; 62% of the 2,134 social service agency clients with no fixed address were single males.

- 52% of agency clients with no fixed address and 41% of hostel residents were under 25 years of age.

- Abused women and ex-psychiatric, alcohol and drug patients accounted for less than 10% each of hostel users.

- 52% of hostel users previously lived in private rental units which were lost due to eviction or rent increases; 8% originated in family homes, and the remainder came from other hostels.

- Among hostel users 87% reported either no income or receipt of public welfare.

- The largest increases in hostel client groups over the past two years were among youth, ex-psychiatric patients and unemployed, willing to work persons.

The authors concluded that the factors leading to homelessness include a decline in affordable rental stock (especially rooming houses), low rental vacancy rates, high unemployment and provincial policies on deinstitutionalizing psychiatric patients. Low-income singles are particularly vulnerable since they are not eligible for assisted housing unless they are disabled or over 60 years of age. Furthermore, existing provincial shelter allowances are not keeping pace with cost of renting in the private market. Finally, the authors took the position that permanent housing solutions must be found; for example, increasing the supply of rooming houses, bachelor apartments and boarding homes for low-income singles would reverse the trend towards hostels becoming permanent homes due to lack of affordable alternatives.

V) "METROPOLITAN TORONTO TASK FORCE ON HOUSING FOR LOW INCOME SINGLE PEOPLE: FINAL REPORT" November, 1983

Summary

On November 1, 1983 the Task Force on Housing for Low Income Single People presented their final report to the Metropolitan Toronto Community Services and Housing Committee.

The Task Force was established to develop concrete solutions to problems identified by the study "No Place to Go...". In addition to regular meetings to explore housing options for single people, the Task Force held public meetings in area municipalities, special meetings with representatives of the non-senior, low-income single population and interviews with experts in the field of housing, they studied housing developments existing presently to serve low-income singles, and held frequent discussions with community agencies and organizations which are working towards solutions for the crisis in affordable housing.

The target population for the Task Force was identified as "...young and middle-aged rooming house occupants for whom hostels are not appropriate...accommodation, but who are unable to afford rental accommodation in the private market...". The Task Force excluded from consideration, "...individuals who would more appropriately be accommodated in supervised residential environments such as...group homes or other...therapeutic residential environment(s)."

The target population was broken down by the Task Force into sub-groups according to group characteristics and housing needs. These sub-groups of the non-senior, low-income single population experiencing housing problems are: temporarily unemployed persons; persons displaced due to conversion, de-conversion, sale or demolition of their dwellings; persons with chronic and perpetual housing problems; transients; and youths.

The Task Force concluded that affordable housing options are severely limited for non-senior, low-income singles, and can only be expanded if senior levels of government make a commitment to address the needs of this population. Among the twenty-nine recommendations made by the Task Force were:

- that Metropolitan Council establish the position of Housing Advisor to facilitate development of affordable housing.

- that area municipalities encourage the Province to amalgamate regulations relating to building safety standards (e.g., Ontario Building Code and Ontario Fire Code).

- that area municipalities develop a standard definition of rooming, lodging and boarding houses in municipal by-laws.

- that Canada Mortgage and Housing Corporation provide additional unit allocations for non-senior, low-income single people.

- that the Ministry of Municipal Affairs and Housing provide that incentive programs for upgrading or converting rental properties be designed in such a way as to protect existing tenants.

- that the Ministry of Community and Social Services increase the shelter subsidy portion of the General Welfare Assistance (GWA) rate for singles living in private rental accomodation.

- that Metropolitan Toronto Community Services Department give homeless GWA applicants an advance entitlement to assist in obtaining accomodation, thus becoming eligible for GWA benefits.

- that the Ministry of Municipal Affairs and Housing extend the eligibility for rent-geared-to-income assistance to include low-income single people below age 60.

VI) "METROPOLITAN TORONTO ASSISTED HOUSING STUDY, PART 1: DETERMINATION OF THE NEED FOR ASSISTED HOUSING". Metropolitan Toronto Planning Department, April 1983

Summary

In June 1981 Metro Council approved a proposal for a study to estimate the need for low-income assisted housing in Metropolitan Toronto. The second part of this study to be released to date is a quantitative survey measuring need for housing assistance based on one's present housing situation.

A questionnaire was mailed to approximately 7,700 households in Metro Toronto which sought information on affordability, suitability (crowding defined as more than one person per room or two persons per bedroom), and physical adequacy (e.g., toilet and kitchen facilities and need for major repairs) as aspects of housing need. Need was broken down by household type (single and two-parent families, childless couples and non-family households) and age of head (senior/non-senior). The senior group was composed of both home-owners and tenants; all other households in the study were tenant households.

A number of conclusions were reached from the results of the study. The most significant ones were:

- There are an estimated 75,800 tenant households and 15,500 senior homeowners needing housing assistance in Metropolitan Toronto.

- Families with children have the highest incidence and severity of need, and account for 35,000 households requiring assistance.

- Single-parent families have a much greater magnitude of need than two-parent families, although the latter has a greater incidence of need. Single-parent families in the private rental market are cutting back on basic requirements to pay for accommodation.

- There are an estimated 20,900 non-senior tenant households that need assistance but are not eligible for any low-income assisted housing programs.

VII) "A NEW HOUSING AGENDA FOR METROPOLITAN TORONTO" Social Planning Council of Metropolitan Toronto March 1984

This latest Social Planning Council report on housing is a comprehensive and detailed analysis of housing policies and programs for low and moderate-income housing in Toronto.

The report begins with an historical overview of social housing policy and programs in Metropolitan Toronto from 1945 to the present day. The discussion deals with government programs at all levels in the context of how they have influenced existing low-income housing in Toronto, concluding that recent trends demonstrate a diminishing public commitment to housing the needy.

An assessment of the need for assisted housing in Metropolitan Toronto is based upon modification of projections made by the Metropolitan Planning Department in 1983. The authors of this report maintain that estimates from the Metropolitan Toronto Assisted Housing Study underrepresented the actual numbers of persons needing assisted housing by a factor of roughly four. According to the present report a realistic estimate of those needing housing assistance in Metropolitan Toronto over the next 15 years is 110,000 households.

An evaluation of present and past federal and provincial housing programs together with estimates of need lead the authors to conclude that the most effective means of meeting need for housing is through provision of rent-geared-to-income housing in both mixed-income housing programs and small-scale public housing projects. The "new housing agenda" included recommendations:

- that senior levels of government authorize 4,500 rent-geared-to-income units annually in Metropolitan Toronto (as of March, 1984, no units have been authorized for this year).

- that senior levels of government improve the effectiveness of existing social housing programs by: a) permitting up to 50% of units in municipal non-profit buildings and other non-profit projects to be rented on an RGI basis; b) revising current methods of determining low-end of market rents in non-profit housing projects.

- that provincial and municipal grant/loan programs be established to assist in rehabilitation of physically inadequate rental accommodations.

- that shelter allowances in provincial and municipal social assistance payments be increased.

- that a certain proportion (16%) of the overall assisted housing target each year be designated for permanent housing for low-income singles.

VII) THE FINAL REPORT OF THE MAYOR'S ACTION TASK FORCE ON DISCHARGED PSYCHIATRIC PATIENTS" Dr. Reva Gerstein, Chairperson March, 1984

Summary

In February 1983 Mayor Eggleton asked Dr. Reva Gerstein to chair a task force inquiring into conditions for discharged psychiatric patients living in Toronto. The objective of the task force was to identify significant problems facing discharged psychiatric patients and explore proposals for solving those problems. The final report is based on a lengthy series of consultations, including public meetings, and incorporates responses to a preliminary report released in November, 1983.

After presenting an overview of Toronto's situation with respect to discharged psychiatric patients, the report concludes that lack of appropriate, affordable housing is the number one problem facing discharged patients. Accordingly, provision of housing options is seen as the key to improving "aftercare" (post-discharge care) and reintegration into the community.

Adequate housing in and of itself does not constitute aftercare. Thus, support services must be available in conjuction with housing to enable ex-psychiatric patients to make their way in the community. The term "supportive housing" refers to a variety of housing-support service options ranging from "...24-hour supervision to weekly support and on-call supervision". In terms of housing options available to ex-psychiatric patients in Toronto, the most common residential arrangements are boarding homes (rooming, lodging houses) which do not offer support services, and group homes (residential care facilities) which involve high levels of support for residents.

Problems exist in Metropolitan Toronto with both of these alternatives. Because of local public objections to group homes and restrictive zoning in some communities, and because of the considerable financial commitment and planning required to establish a group home, there are relatively few of them in comparison with the overwhelming demand. The report recommends, therefore, that support for group homes be reaffirmed and that each municipality in Metropolitan Toronto demonstrate its commitment to the benefits of group homes by making a facility available in their community immediately for non-profit use as a group home.

Boarding houses constitute the principal source of residential accommodation for discharged psychiatric patients in the City of Toronto. The problem with boarding homes is that they are not

governed by standards for personal care, and enforcement of physical standards often may lead to owners going out of business, and/or eviction of residents.

In view of the necessity for improvements in boarding homes that would take into account the needs of ex-psychiatric patient residents as well as the owner/operators of these marginal businesses, the report contains a proposal for a Contract Aftercare Project (CAP). CAP is a proposal for providing funding to boarding house owner/operators catering primarily to discharged psychiatric patients to upgrade the physical and service standards of their properties. Contracts between the municipality and boarding home owner/operators would include a provision for delivery of aftercare programs on the premises by approved social service agencies. Thus, the report recommends that an agreement be made between the Province and the City of Toronto to establish such a program, beginning in the Parkdale area. Additionally, the report recommends that an implementation committee be struck to administer the CAP, composed of representatives from Provincial, Metropolitan and City of Toronto governments, including a representative from the Medical Officer of Health and the Commissioner of Buildings and Inspections.

Board of Health October 11, 1984

Appendix C

RECOMMENDATIONS OF THE INTERDEPARTMENTAL TASK FORCE ON AFFORDABLE HOUSING

Land Use Committee November 7, 1983

RECOMMENDATIONS:

1. That the January 31, 1983 decision of the Land Use Committee respecting the September 24, 1982 report of the Interdepartmental Task Force on Affordable Housing be modified by deleting all of Recommendation 1.2 and its constituent sections as contained in the aforesaid report, and replacing it with a new Recommendation 1.2, substantially as set out below:

"1.2. That the City Solicitor, in consultation with the Commissioners of Planning and Development and Buildings and Inspections, prepare draft by-laws to give effect to the following general amendments to Zoning By-law 20623:

1.2.1 the definition of apartment house is amended to read substantially as follows:

"apartment house means a building other than a triplex dwelling house, a double triplex dwelling house, a double duplex dwelling house, an apartment-hotel, a converted dwelling house or a converted dwelling and lodging house, containing three or more dwelling units and may contain one or more dwelling rooms provided that no such dwelling room has been created as a result of the conversion or renovation of all or part of a dwelling unit that was in existence prior to the year 1976, but does not include a building coming within the definition of tourist establishment as defined in The Tourist Act, R.S.O., 1970, Chapter 122, as amended or as it may be further amended from time to time";

1.2.2 the definition of converted dwelling house is amended to read substantially as follows:

"converted dwelling house means a building originally constructed as a private detached dwelling house, a one-family dwelling house, a

duplex dwelling house, a triplex dwelling house, a double duplex dwelling house or a double triplex dwelling house, which, including any addition made prior to conversion, is at least 5 years old, which has been or is proposed to be altered or converted so as to provide therein two or more dwelling units";

1.2.3 the definition of converted dwelling and lodging house is amended to read substantially as follows:

"converted dwelling and lodging house means a building originally constructed as a private detached dwelling house, a one-family dwelling house other than row housing, a duplex dwelling house, a triplex dwelling house, a double duplex dwelling house or a double triplex dwelling house, which, including any addition made prior to the conversion, is at least 5 years old, which has been or is proposed to be altered or converted so as to provide therein one or more boarding or lodging rooms and may contain one or more dwelling units";

1.2.4 the definition of boarding or lodging house is amended to read substantially as follows:

"boarding or lodging house means a dwelling house originally constructed for the purpose of providing lodging for gain with or without meals and contains boarding or lodging rooms and not more than two dwelling units but does not include an hotel, hospital, children's home, home for the aged, apartment house or other establishment otherwise classified or defined in this by-law";

1.2.5 the deletion of any provision restricting culinary facilities or sinks in boarding or lodging rooms;

1.2.6 the deletion of any general reference in the Zoning By-law to the permitted number of boarding or lodging rooms in boarding or lodging houses and in converted dwelling and lodging houses;

1.2.7 the deletion of any general reference in the Zoning By-law to the permitted sizes of dwelling units, boarding or lodging rooms and dwelling rooms,

except for the provisions that apply to senior citizens housing and single persons housing;

1.2.8 the deletion of restrictions to the number of dwelling units per hectare of lot area in any R, C1S or C1 district, as contained in Section 16(2) of the Zoning By-law;

1.2.9 the deletion of special restrictions on additions and alterations to boarding or lodging houses, converted dwelling houses and converted dwelling and lodging houses that do not relate to the facade treatment of same as viewed from the streets upon which they front and/or flank;

1.2.10 the deletion of special requirements for sanitary facilities and for the exterior maintenance of boarding or lodging houses and covered dwelling and lodging houses, as contained in Sections 8(3)(v) and 8(3)(vi) of the Zoning By-law:

1.2.11 the repeal of Section 16(2), which prohibits the conversion of an apartment house to a boarding or lodging house:

1.2.12 the inclusion of a boarding or lodging house as a permitted use in R1A, R2, R3, R4 and R4A districts;

1.2.13 the inclusion of a converted dwelling and lodging house as a permitted use in CR and QR districts;

1.2.14 the inclusion of dwelling rooms as a permitted use in the upper portion of a C1 building in a C1 district but not in C2, C3 or C4 districts; and

1.2.15 the inclusion of wording in Sections 8(3) and 8(9) of the Zoning By-law in order specifically to permit the act of converting the uses mentioned."

2. That the Commissioner of Planning and Development report further on the appropriate conversion factor to be applied to dwelling rooms in CR and QR districts for the purposes of density calculations.

3. That the Commissioner of Planning and Development, in consultation with other appropriate officials, report further on the outstanding concerns related to the supervision of a boarding or lodging house and a converted dwelling or lodging house by an owner or bona-fide tenant.

Board of Health

October 11, 1984

Commissioner of Planning and Development

Commissioner of Buildings and Inspections

Commissioner of Housing

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POOR

QUALITY

ORIGINAL